APPEAL NO. 93382

This appeal arises under the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-1.01- *et seq.* (Vernon Supp. 1993) (1989 Act). On April 8, 1993, a contested case hearing (CCH) was held in (city), Texas with (hearing officer) presiding as hearing officer. The sole issue to be resolved at the CCH was: "Has CLAIMANT reached maximum medical improvement with a 5% impairment rating as assigned by the Commission designated doctor?" The hearing officer determined that the appellant, claimant herein, reached MMI with a five percent (5%) impairment rating and that the great weight of the other medical evidence was not contrary to the opinion of the designated doctor.

Claimant contends that the great weight of the medical evidence is contrary to the designated doctor and that the treating doctor's 29% impairment rating was the correct rating and requests we review the case. Respondent, carrier herein, responds that it concurs in the decision of the hearing officer.

DECISION

The decision of the hearing officer is affirmed.

Claimant testified that he was injured when he jumped about three feet off the floor of a drilling rig onto the ground, bent over to pick up a tool and felt pain. The injury is not in dispute. Claimant first saw (Dr. C), M.D., the company doctor, who said he could go back to work the next day. However, claimant testified that he couldn't even get out of bed the next day. Claimant testified he then first saw (Dr. S), D.C., and then (Dr. Z), M.D. Claimant eventually saw a number of other doctors including (Dr. M), M.D., carrier's medical examination (MEO) doctor. Based on Dr. M's certification of MMI and failure to assign an impairment rating, a designated doctor was requested to be appointed. (Dr. D), M.D., was selected by the Commission as the designated doctor. In July 1992, the claimant was seen by the designated doctor who initially said claimant had not reached MMI. Dr. D, the designated doctor, eventually certified MMI on December 22, 1992 and referred claimant to an associate, (Dr. Ca), M.D., for an impairment rating. Dr. Ca certified claimant as reaching MMI on January 13, 1993, with a five percent whole body impairment rating. This report was subsequently reviewed and adopted by Dr. D.

The medical evidence consisted of a Report of Medical Evaluation (TWCC-69) from Dr. Ca dated 1/13/93 certifying MMI on 1/13/93 and assigning a five percent whole body impairment rating. The attached narrative reflects claimant was evaluated at "5% impairment for his specific disorder, 0% impairment for ROM [range of motion] and 0% impairment for neurologic deficit." This was combined for five percent impairment of the whole person.

A medical report of Dr. D dated July 6, 1992 recites the medical history, an MRI diagnosis of "facet arthropathy on the right at L4-5 and L5-S1 . . . [and] early facet arthropathy on the left at L4-5 and L5-S1." This report recited the findings of Dr. M and (Dr.

Ch), a psychologist. Dr. D in this report concludes that claimant has "mechanical back injury with chronic lumbar facet syndrome, superimposed on preexisting degenerative arthritis and degenerative disc disease." Dr. D states the patient has not reached MMI (in July 1992) and suggests "trial of facet joint injections and possible fact rhizotomies." There is no report from Dr. D as to claimant's second visit and on December 22, 1992 Dr. D, certified claimant had reached MMI and referred claimant to Dr. Ca for an impairment rating, as noted above.

Dr. Z's report of 1-27-92, after recounting the history, finds "Lumbar strain, no specific nerve root compression identified. Degenerative osteoarthritis by x-ray. [Claimant] had multiple levels of degenerative osteoarthritis in the lumbar spine."

Dr. C, the company doctor, on an Initial Medical Report (TWCC-61) diagnosed "muscle strain."

Dr. M, the carrier's examining doctor, by report dated April 29, 1992 has a diagnostic impression of "[d]elayed evolution, lumbosacral sprain, not practically healed." Dr. M comments that claimant was being referred back to the attending physician, Dr. S, "to use the modality of occupational therapy." Dr. M notes claimant's obesity and states ". . . it is very difficult to get rid of the pain completely in people with obesity. Obesity is one of the big troubles in low back pain."

Odessa Physical Therapy (OPT) in a memo dated 11/17/92 recites history, findings, and tests conducted, stating:

> . . . the patient refused these tests and stated that he could not bend his knees and complained of significant increase in symptomatic pain at which time vital signs were taken with a heart rate of 100.
>
> [Claimant] presented at OPT with major restrictions for movement loss in his low back area. He has a very descriptive pain drawing with pain in his back and anterior and posterior right lower extremity. He offered significant levels of symptomatic pain with positive soft signs for some disc involvement. Based upon static testing, his willingness to perform the tests, and his significantly increased pain level state, it is felt that the FCE would not provide a valid representation of his functional capacity at this time.

By report dated November 23, 1992, OPT suggested a treatment plan for claimant stating OPT ". . . would like to treat [claimant] for 1-2 months for pain reduction and flexibility training . . . ." By report dated December 21, 1992 OPT states claimant "reported no decrease in his pain symptoms." The report states claimant attended all scheduled sessions and performed all exercises asked of him. OPT recommended claimant be dismissed ". . . from

structured treatment program . . . as he does not appear to benefit significantly from any physical therapy offered him . . . ." They recommended claimant be given an impairment rating.

(Dr. R), M.D., performed a lumbar spine MRI and by report dated 3/10/92 noted "[d]iffused disc bulge at L4-L5 level somewhat more marked on the right side . . . evidence of facet arthropathy in the lower two facet joints more marked on the right side."

(Dr. H), M.D., on a referral from Dr. S by letter dated August 11, 1992, states:

> I made [claimant] a money-back written guarantee that if he were to lose 100 lbs, plus exercise on a regular basis, that within a year, I would guarantee his back would be remarkedly improved. After [claimant] stopped laughing, we then proceeded with the evaluation.
>
> My plan would be to do a facet injection, as well as a medial branch of the posterior primary ramus at L4 and L5. This would hopefully give him some relief from his facet arthropathy. The facet injection, although questionable, does give some relief and when used in conjunction with the medial branch has been successful in my hands.

In a subsequent report dated August 31, 1992, Dr. H sent claimant back to Dr. S stating:

> His MRI showed no disc problems; however there was evidence of abnormal discs at L4-5 and L5-S1.
>
> His major problem is that he is 5'9" and weighs over 250 lbs. I do not think a discogram would be beneficial, as he is not a good candidate for surgery. His success rate would be poor, especially with his added weight.
>
> I understand that he is has obtained some good relief from a MUA. I think this would be a called for maneuver at this time. I also believe that a repeat may be necessary.

Dr. Ch, a clinical psychologist, submitted a report dated June 16, 1992, but does not made any pertinent findings. (Dr. Ct), M.D., submitted a report dated May 27, 1992 on a referral from Dr. S and only recommended continued therapy and medication.

The most recent and comprehensive reports were from Dr. S, the treating doctor. The TWCC-61 dated 1/22/92 indicated muscle spasms with loss of ROM and a treatment plan of "interferential and spinal manipulations." Another TWCC-61, dated 03/26/92 shows "poor" sub-maximal bike testing and body composition. Treatment goals were pain

management, increase ROM and weight loss. In a Specific and Subsequent Medical Report (TWCC-64) dated 6-30-02, the report showed improvement in ROM, decrease in pain with a treatment plan to increase ROM endurance and "aggressive back strengthening protocol." Additional TWCC-64s dated 04-01-92; 5-11-92; 7-1-92; 7-17-92; 09-01-92; 10-7-92; and, 11-3-92 traced claimant's progress. Manipulations under anesthesia (MUA) were performed 4/16/92 and 4/17/92. By TWCC-69 (undated) Dr. S stated: "I, the treating physician, am disputing the evaluation of [Dr. M]. Attached you will find [Dr. M's] report of examination, which I was present for, on April 29, 1992." By letter dated February 4, 1992, to the Commission Dr. S states: "This letter is to notify the TWCC that I am disputing the impairment rating that was given by [Dr. Ca] on the above mentioned patient." In a letter dated December 22, 1992 Dr. S stated:

> [Claimant] was seen by [Dr. D] three times, I was present at each of these appointments. At the first visit in August [Dr. D's] suggestion was to try rhizotomies and facet injections.
>
> [Dr. H] performed the injections in Lubbock. Results: NONE
>
> At the second visit in December I suggested to [Dr. D] that we do the Manipulations Under Anesthesia again to restore some function to [claimant] and to lower his impairment. [Dr. D] suggested we stop the rehab program at our facility and try an "aggressive" rehab program at [OPT]. This consisted of three weeks of daily visits. During the first week rehab consisted of ultrasound, heat, stimulation. During the second week rehab consisted of massage and some stretching. At the end of the second week the upper cycle was added for six minutes at a bout.
>
> During the third week some weights were added for upper extremities, continuing upper cycle and stretching.
>
> The third visit to [Dr. D] was on December 22, 1992. [Dr. D] said "the rehab didn't help, nothing probably will". So he released [claimant] at Maximum Medical Improvement and suggested retraining by Texas Rehabilitation Commission. I said that since neither [Dr. D] nor the insurance company would allow any more MUA's on [claimant], that he would not progress anymore.
>
> I did my Impairment Rating on December 22, 1992. [Claimant's] 29% whole person impairment is something that I wanted to decrease, however was not given the chance. [Claimant] will have to be retrained or go on permanent disability.

Dr. S, by TWCC-69 dated 02-04-93, certified MMI on 12-22-92 with a 29% impairment

rating.

The hearing officer determined in pertinent part:

FINDINGS OF FACT

4.CLAIMANT was certified as reaching maximum medical improvement on April 29, 1992, by [Dr. M], CARRIER's requested medical examination doctor. [Dr. M] did not assign an impairment rating. CLAIMANT disputed this certification and [Dr. D] was appointed as a Commission designated doctor.

5.[Dr. D] did not initially consider CLAIMANT at maximum medical improvement and suggested several treatments be tried for facet syndrome. [Dr. D] certified CLAIMANT as reaching maximum medical improvement on December 22, 1992, but referred him to [Dr. Ca] for a impairment rating.

6.[Dr. Ca] assigned CLAIMANT a 5% whole body impairment rating based on specific diagnosis, assigning a 0% impairment rating to range of motion due to invalidity, specifically, the sum of the sacral flexion and extension exceeded the tightest straight leg raise by more than 10 degrees.

7.[Dr. D] concurred with and adopted the impairment rating assigned by [Dr. Ca].

8.The great weight of the other medical evidence is not contrary to the opinion of the designated doctor.

CONCLUSIONS OF LAW

2.Absent a finding that the great weight of the other medical evidence is to the contrary, the commission shall base its determination as to whether the claimant has reached maximum medical improvement on the report of the commission designated doctor; therefore, CLAIMANT reached the point of maximum medical improvement on January 13, 1993, with a five percent (5%) impairment rating.

Claimant's appeal was joined by Dr. S who stated "[Claimant] and I ([Dr. S]) are disputing the decision made by the hearing officer . . . ." The appeal concludes "[claimant] and I are now requesting that the Appeals Panel review this case . . . ." Dr. S, as stated in his reports, accompanied claimant in claimant's office visits to the designated doctor, appeared in person and testified on behalf of claimant at the CCH and has prepared the appeal.

The appealed issue, as we understand it, is the impairment rating. The appeal does not contest the MMI date and both Dr. S, the treating doctor, and Dr. D, the designated doctor, have certified MMI in either December 1992 (Dr. S certified MMI December 22, 1992) or January 1993 (Dr. D initially certified MMI on December 22, 1992 but subsequently adopted Dr. Ca's certification of January 13, 1993). As MMI is not an appealed issue we will not address it.

Regarding the issue of impairment rating, the 1989 Act provides that if there is a dispute and the parties are unable to agree on a designated doctor, the Commission will select a designated doctor to examine the claimant. Texas Workers' Compensation Commission Appeal No. 93105, decided March 26, 1993, provides an excellent overview of our position on that issue. We have held in such case, "the report of the designated doctor shall have presumptive weight and the Commission shall base the impairment rating on that report unless the great weight of the other medical evidence is to the contrary . . . ." Article 8308-4.26(g). We have repeatedly emphasized the unique position occupied by the designated doctor under the 1989 Act. *See* Texas Workers' Compensation Commission Appeal No. 92555, decided December 2, 1992; Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. It is not unusual to have disagreement or some degree of disparity between the reports of various doctors who have treated or examined an injured worker. *See generally*, Texas Workers' Compensation Commission Appeal No. 92561, decided December 4, 1992. As we observed in Appeal No. 92412, *supra*, this was something the legislature must have envisaged in enacting Articles 8308-4.25 and 4.26, which provide a mechanism, namely the designated doctor, when there is a dispute involving MMI or impairment rating. In Appeal No. 92412, we went on to point out that to outweigh the report of a designated doctor requires more than a mere balancing of the medical evidence or a preponderance of medical evidence; rather, such other medical evidence must be determined to be the "great weight" of the medical evidence contrary to the report.

Regarding claimant's complaint that the impairment rating was done by Dr. Ca, rather than the designated doctor, we have held that the designated doctor is not precluded from ordering referral examinations to assist the designated doctor in the evaluation of impairment. Texas Workers' Compensation Commission Appeal No. 93007, decided February 18, 1992 and Texas Workers' Compensation Commission Appeal No. 92627 decided January 7, 1993. TWCC Advisory 93-04 is accurately quoted in the appeal and clearly does not preclude the designated doctor from referring claimant to an associate for an impairment rating, provided the designated doctor has also personally examined and evaluated the claimant. It is undisputed that Dr. D, the designated doctor, examined claimant on three occasions, in Dr. S's presence, that Dr. D initially found MMI had not been reached and later determined and certified MMI had been reached. At this point Dr. D referred claimant to his associate, Dr. Ca, who did impairment testing and arrived at an

impairment rating. At that point Dr. D reviewed Dr. Ca's tests and rating and on the TWCC-69 dated 1-13-93 specifically stated "Addendum; I concur with [Dr. Ca's] impairment rating" and signed the report. The hearing officer notes "[Dr. Ca] is an M.D. and an impairment specialist." The hearing officer's comments on what a "physical therapy assistant" might do in another case is dicta because no physical therapy assistant was involved in this case.

We are mindful of a similar case, Texas Workers' Compensation Commission Appeal No. 92286, decided May 28, 1993, where we reversed and remanded the hearing officer who had given presumptive weight to a designated doctor's report. We would distinguish Appeal No. 92286 from the instant case on the basis that the ground for reversal in Appeal No. 92286 was the specific attack by the claimant on the designated doctor's failure to use inclinometer measurements, thereby failing to fully and correctly apply a specific protocol of the AMA Guides to the Evaluation of Permanent Impairment, Third Edition (AMA Guides). No such attack was made in this case; instead, claimant disputes the correct principles for calculating impairment and the effect of certain invalid test measurements. Dr. Ca recites that the impairment procedure and measurements were done according to the AMA Guides. Dr. Ca found the straight leg raising tests invalid because of inconsistency. We are unwilling to say, as a matter of law, that measurements must be repeated and examinations deferred, *ad infinitum*, until valid measurements can be obtained before an impairment rating can be made.

The arguments claimant makes in paragraph 3 that the AMA Guides were not followed were made in person by Dr. S at the CCH and were in Dr. S's reports. The hearing officer clearly considered those arguments, heard quoted sections of the AMA Guides and asked Dr. S several questions regarding his position on the accuracy of Dr. Ca's impairment rating. We cannot say, as a matter of law, that the hearing officer erred in failing to adopt Dr. S's interpretation of the AMA Guides. We do agree with claimant that the theory behind the use of the AMA Guides is that two physicians following the same medical evaluation protocol on the same patient, using the same reference tables and reporting protocol "should report very similar results and reach very similar
conclusions." This may be true in theory, however, this is an issue of fact to be addressed by the hearing officer.

Dr. S, in claimant's appeal, seems to be saying that had he, Dr. S, been allowed to do the therapy ordered by Dr. D and had been allowed "to perform another set of MUA" claimant's "impairment rating could have been lowered from a 29% . . ." We interpret this as speculating that Dr. S's therapy and MUA would have been more successful than the OPT therapy. There is no evidence to support this contention.

In summary we find no sound basis for us to declare, in opposition to the finding of the hearing officer, that the great weight of other medical evidence is contrary to the rating of the designated doctor. As we have noted, no other doctor's report, including a report of

a treating doctor, is accorded the special presumptive status as the designated doctor's report. Appeal No. 92412, *supra*, and Texas Workers' Compensation Commission Appeal No. 92366, decided September 10, 1992.

In the area of fact finding, the 1989 Act clearly provides that the hearing officer is the sole judge of the relevance and materiality of the evidence and of the weight and credibility to be given the evidence. Article 8308-6.34(e). In fulfilling this responsibility, the hearing officer, as the finder of fact, resolves conflicts and inconsistencies in the testimony and evidence. Burelsmith v. Liberty Mutual Insurance Co., 568 S.W.2d 695 (Tex. Civ. App.-Amarillo 1978, no writ); Texas Workers' Compensation Commission Appeal No. 92234, decided August 11, 1992. Only were we to find, which we do not in this case, that the determination of the hearing officer was so against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust would we have a sound basis to disturb the decision. In re King's Estate, 224 S.W.2d 660 (Tex 1951); Texas Workers' Compensation Commission Appeal No. 92232, decided July 20, 1992.

The decision is affirmed.

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Thomas A. Knapp
Appeals Judge

CONCUR:

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Susan M. Kelley
Appeals Judge

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Lynda H. Nesenholtz
Appeals Judge